THREE PEAKS
COUNSELING

CLIENT INFORMATION AND INSURANCE REGISTRATION

First Name:_____ M.I.:___ Last Name:_____

SS#:_____ Birthdate:_____

Address:_____

City:_____ State:_____ Zip:_____

Tel: Home: _____ Okay to leave message? (Circle one) Yes No

Tel: Work:_____Ext_____ Okay to leave message? (Circle one) Yes No

Tel.: Cell_____ Okay to leave message? (Circle one) Yes No

Which number do you prefer us to call and leave message? (Circle one) Home Work Cell

Employer:_____ Address:_____

INSURANCE INFORMATION
(Complete the following if using insurance benefits)

Insured's First Name:_____ M.I.:___ Last Name:_____

SS#:_____ Birthdate:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Relationship to Patient:_____

Employer:_____ Address:_____

PRIMARY INSURANCE:

Insurance Company:_____ Address:_____

Insured's ID#:_____ Group/Plan#:_____

Phone #: _____

SECONDARY INSURANCE:

Insurance Company:_____ Address:_____

Insured's ID#:_____ Group/Plan #:_____ Group Name:_____

Phone: _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself, my provider, or Three Peaks Counseling.

Client Signature: _____ Date: _____

I authorize payment of medical benefits to my provider or Three Peaks Counseling for services.

Client Signature: _____ Date: _____

For office use only
Date:_____

Insurance Rep_____

Effective Date_____ Deductible _____ Fam Ded_____

Deductible Remaining_____

In Network_____ Patient Co-Pat/Co-Ins_____

Maximum Visits or Amount Paid_____

Authorization Required?_____ Authorization #_____

Out of pocket maximum: _____